TRACKING BENEFICIARY REIMBURSEMENT CLAIMS (CONLAN)													
Date Received	**Beneficiary Claim #**	**Beneficiary Name**	**Date to Provider**	**Follow-up Date**	**Provider Payment Date**	**Date Ltr #10 Sent w/copy to DMH**	**Provider Denial Date**	**Reason Provider Denied Claim**	**Date Ltr #7 Sent w/copy to DMH**	**MHP Payment Date**	**Claim Closed Date**	**Date Claim Returned to DMH**	**Notes/Comments**